STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/26/16 through 07/28/16. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 96 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents # 1 through #17) and 3 closed record reviews (Residents # 18 through #20).	F 000		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.15(h)(2) The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to ensure a safe, clean, comfortable and homelike environment in common areas of the facility. The facility staff failed to ensure housekeeping and maintenance services were provided to maintain sanitary, orderly and comfortable common areas throughout the facility. Findings include: During general observations of the facility	F 253	The Maintenance Director and House Keeping Supervisor began on 8/16/16 with corrections in the following areas: ceiling tile at vending machine area, cleaning of vending machine area, old laundry chute area, dining room area, repairs to wall in vending machine area, and repair to the cove base. These corrections will be completed by 8/19/16. The Director of Nursing in-serviced the Supply Clerk on Environmental Rounds on 8/17/16. The Supply Clerk completed a	8/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/18/2016

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F 253	Continued From page 1 environment on 07/26/16 through 07/28/16, several common areas throughout the facility were found unsanitary and poor repair. On 07/27/16 at approximately 8:00 a.m., the hall area (near the vending machine and smoking area exit door) was found to have a hole in wall, just outside the vending machine area. An old laundry chute, in this same area was found to have peeling molding, much of which was barely attached and exposed caulking/silicone type of material. The area had visible dirt/debris. A staff member passing by voiced that the laundry chute was no longer in use. Additionally in this same area, the ceiling tiles around a sprinkler were noted to be cracked and peeling and had visible stains. The vending machine area was in the hall, behind double doors. The area behind the doors housed three vending machines. The wall on the right had a large crack down the seam of the dry wall and at the bottom the area was broken and crumbling. Trash was observed on top of the vending machines and on the left side of the machines was a moderate quantity of dirt/debris, a rock, a cigarette butt and pieces of trash laying in the floor. The floors had were visibly dirty. No trash receptacle was observed in this area. The dining room area was noted to have scuff marks on and around the painted walls. One entire wall in the dining room area did not have any baseboard molding, there was only patches of old chipped paint and old adhesive stuck to the wall area, where molding had once been.	F 253	100% Audit of facility on 8/17/16 for any areas needing repair to include cleaning and monitoring for excessive temperatures. Any areas of concern were address immediately by the housekeeping supervisor and/or Maintenance Director. All License nurses, CNAs, Dietary staff, therapy staff, housekeeping staff, and department managers were in-serviced by the Staff Facilitator on completing work orders for any areas of building that need repairs to be completed by 8/19/16. All newly hired staff will be in-serviced regarding completing work orders for any areas of building that need repairs in orientation. The Administrator in-serviced the Maintenance Director and House Keeping supervisor on 8/17/16 on maintaining the facility in a sanitary and working order to include checking for and completing work orders. The Maintenance Director and House Keeping Supervisor will complete walking rounds daily Monday through Friday to identify areas needing repairs, cleaning, or excessive heat of the facility and to ensure a safe, clean, comfortable homelike environment in common areas of the facility and document findings on Rounding Sheets. The Director of Nursing will complete walking rounds to ensure the maintenance director and housekeeping supervisor has ensured all areas were identified, repaired and cleaned as appropriate utilizing the Department Rounding Tool weekly x 8 weeks then monthly x 1 month. Any areas of concern will be address immediately	

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F 253	Continued From page 2 A group meeting was held with several cognitively intact residents on 07/27/16 at 10:15 a.m., the majority of the group voiced that the vending machine area was often hot and when they would purchase candy bars and items similar to that, they would often be melted from the heat. The group did not voice that this concern had been reported to facility staff. The administrator, DON (director of nursing), nurse consultant and regional vice president were made aware of the above concerns during a meeting with the survey team on 07/27/16 at approximately 1:45 p.m. The administrator and regional vice president agreed that this was an old building and voiced that the dining room area was a 'work in progress' and that they (the facility) were in the process of replacing the baseboard molding in the dining room area. The administrator and regional vice president were asked if there was a work order. The regional vice president voiced, not necessarily. The nurse consultant then voiced that the facility was in the process of purchasing materials. An interview with Resident # 12 was conducted on 07/28/16 at approximately 8:00 a.m., the resident voiced that the facility is old and isn't as clean as it should be and further voiced that staff had been working and cleaning a lot, since the surveyors were here. No further information or documentation was presented prior to the exit conference on 07/28/16 at 10:15 a.m.	F 253	with retraining to the maintenance director and housekeeping supervisor. The Administrator will initial and review the Department Rounding Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will compile audit results of the QI Tool: Department Rounding Tool and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Administrator is responsible for overall compliance.	
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		8/22/16

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F 280	Continued From page 3 CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 20 residents in the survey sample. The care plans for Residents #2 and #15 were not updated regarding one to one supervision provided due to safety concerns. The findings include: 1. Resident #2's care plan was not revised to include the one to one supervision and safety checks in place to minimize and/or prevent	F 280	The Care Plans for resident #2 and 15# were updated by the MDS nurse on 8/16/16 to include one on one safety supervision and safety checks. 100% audit of all resident□s to include resident #2 and #15 Care Plans was initiated on 8/16/16 by the Director of Nursing and Assistant Director of Nursing to ensure interventions to include one on one supervision and safety checks were addressed as appropriate and will be completed by 8/22/16. Care plans will be	

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F 280	Continued From page 4 inappropriate sexual behaviors. Resident #2 was admitted to the facility on 12/1/14 with a re-admission on 1/13/15. Diagnoses for Resident #2 included gastrointestinal bleed, anemia, cardiomyopathy, congestive heart failure, duodenal ulcer, hyperlipidemia, urinary tract infection, pedophilia, peripheral vascular disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease and hypertension. The minimum data set (MDS) dated 5/4/16 assessed Resident #2 with moderately impaired cognitive skills. On 7/26/16 at 2:20 p.m. Resident #2 was observed in bed in his room with a certified nurses' aide (CNA) sitting with the resident. On 7/26/16 at 3:50 p.m. Resident #2 was observed in his motorized chair in the dining room accompanied by a CNA. On 7/26/16 at 8:20 a.m. the licensed practical nurse (LPN #3) caring for Resident #2 was interviewed about the one to one supervision in use with the resident. LPN #3 stated Resident #2 made sexual advances to women in the facility. LPN #3 stated the resident required one to one supervision during the day and evening shifts and safety checks every 30 minutes at night to prevent him from inappropriate interactions with female residents. LPN #3 stated the supervision was required because the resident was able to transfer without assistance from bed and had mobility throughout the facility with his motorized chair. On 7/27/16 at 8:30 a.m. CNA #2 sitting with Resident #2 in the dining room was interviewed about the one to one supervision provided for	F 280	immediately revised during the audit for any concerns identified by the MDS nurse. An In-service was conducted by the Facility MDS Consultant on 8/16/16 with the Care Planning Team to include: MDS Nurse, Activity Director, Social Worker, Dietary Manager, Director of Nursing, and Assistant Director of Nursing, and Staff Facilitator on Revision of Comprehensive Care Plans. Any newly hired staff to the Care Planning Team will be in-serviced regarding revision of comprehensive care plans by the Director of Nursing during orientation. The Assistant Director of Nursing will audit 10% of all resident□s care plans to include resident #2 and resident #15 to ensure interventions to include one to one supervision and safety checks are addressed on the resident care plan as appropriate weekly x 8 weeks then monthly x 1 month utilizing the QI Tool: Care Plan Monitoring. The Assistant Director of Nursing will retrain the appropriate care plan team member and ensure the care plan is revised during the audit for any identified areas of concern. The Director of Nursing will review and initial the QI Tool for care plan monitoring for completion and to ensure all areas of concern have been addressed weekly x 8 weeks then monthly x 1 month. The Director of Nursing will compile audit results of the QI Tools: Care Plan Monitoring and present to the Quality Improvement Committee Meeting monthly x3 months. Subsequent plans of action	

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F 280	Continued From page 5 Resident #2. CNA #2 stated one to one supervision was provided starting at 6:00 a.m. each day through 10:00 p.m. each evening because the resident touched female residents inappropriately and made sexual verbal comments to women. CNA #2 stated the resident had mobility in the facility with his motorized chair and was able to get out of bed on his own. The resident's plan of care (revised 5/18/16) listed the resident had inappropriate sexual behaviors. The behaviors listed included making inappropriate remarks, touching staff inappropriately, physical and verbal attempts to get affection from other residents, inserting tubing/straws and/or coffer stirrers into his urethra/penis. Interventions to minimize/prevent sexual behaviors included, "Intermittent supervision when oob [out of bed]" and "1:1 supervision prn [as needed]." The care plan did not include the one to one supervision provided from 6:00 a.m. until 10:00 p.m. each day and failed to mention the checks on the resident every 30 minutes during the night. On 7/27/16 at 9:10 a.m. the registered nurse (RN #1) responsible for care plans was interviewed about Resident #2. RN #1 stated the care plan had not been updated with the current supervision provided. RN #1 stated one to one supervision was in place during the day and evening shifts and checks were performed at night while the resident was sleeping. RN #1 stated the care plan should be more detailed and should include the supervision currently in place with the resident. These findings were reviewed with the administrator, director of nursing and nurse	F 280	will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	

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F 280	Continued From page 6	F 280		

consultant during a meeting on 7/27/16 at 1:45 p.m.

2. Resident #15's care plan was not revised regarding one to one supervision provided due to the resident's aggressive behaviors.

Resident #15 was admitted to the facility on 10/2/09 with a re-admission on 9/15/14. Diagnoses for Resident #15 included personality disorder, psychosis with agitated features, gastroesophageal reflux disease, depression, vascular dementia, cerebrovascular accident (stroke), hypertension, peripheral vascular disease and osteoarthritis. The minimum data set (MDS) dated 7/13/16 assessed Resident #15 as cognitively intact.

On 2/27/16 at 2:55 p.m. Resident #15 was observed in bed with certified nurses' aide (CNA) #5 sitting in a chair at the foot of his bed. CNA #5 was interviewed at this time about the supervision provided for Resident #15. CNA #5 stated one to one supervision was provided during the day and evening for Resident #15 due to his aggressive behaviors toward other residents. CNA #5 stated she thought scheduled checks were done with the resident during the night.

The resident's clinical record documented a physicians' order dated 7/6/16 for one to one supervision when the resident was out of bed and checks at night every 30 minutes due to aggressive behaviors.

The resident's plan of care (revised 5/5/16) listed the resident had ineffective coping skills and demonstrated combativeness and verbal/physical aggression toward others. The care plan stated

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F 280	Continued From page 7 Resident #15 verbally threatened others, hit other residents, taunted other residents and was combative for no apparent reason. The care plan interventions to minimize aggressive behaviors and protect other residents included, "Other non-pharmacological behavioral intervention (1:1 companion prn [as needed])." The care plan made no mention of the physician ordered requirement for one to one supervision when out of bed or the nightly 30 minutes checks. On 7/28/16 at 8:20 a.m. the registered nurse (RN #1) responsible for care plans was interviewed about Resident #15's plan for aggressive behaviors. RN #1 stated the director of nursing or the interdisciplinary team usually let her know when to update or revise the care plan. RN #1 stated Resident #2's behavior care plan was last revised on 6/10/16 and she had not updated the care plan regarding the one to one supervision when out of bed or the nightly checks. RN #1 stated she was not aware of the physician's order dated 7/6/16 regarding the required supervision and nightly checks. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 7/28/16 at 9:30 a.m.	F 280		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		8/22/16

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F 309	Continued From page 8 and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow a physician's order for one of 20 residents in the survey sample. For over three months Resident #2 was administered the medication Lipitor twice per day when the physician ordered the medication once per day. The findings include: Resident #2 was admitted to the facility on 12/1/14 with a re-admission on 1/13/15. Diagnoses for Resident #2 included gastrointestinal bleed, anemia, cardiomyopathy, congestive heart failure, duodenal ulcer, hyperlipidemia, urinary tract infection, pedophilia, peripheral vascular disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease and hypertension. The minimum data set (MDS) dated 5/4/16 assessed Resident #2 with moderately impaired cognitive skills. Resident #2's clinical record documented a physician's telephone order dated 2/25/16 for Lipitor 10 mg (milligrams) to be administered at each bedtime for the treatment of hyperlipidemia. The resident's medication administration records (MARs) for April 2016, May 2016, June 2016 and July 2016 (through 7/26/16) documented 10 mg of Lipitor was administered twice per day instead of once per day as ordered. The MARs had duplicate order entries for the Lipitor 10 mg with nurses documenting the Lipitor was administered	F 309	The MD was notified of Resident #2 receiving Lipitor twice per day instead of the ordered once per day x 3 months, by the Director of Nursing on 7/27/16. New orders were received on 7/27/16 to clarify the Lipitor order for 10mg PO q HS and to obtain a stat Lipid Panel. Corrections were made to resident□s #2 MAR by Director of Nursing on 7/27/16. A stat Lipid was obtained on 7/27/16 with results received on7/27/16 and within normal range. The was MD notified of resident #2 Lipid results by the Director of Nursing with no further orders on 7/27/16. A 100% audit of all current resident□s to include resident #2 physician orders for the last 3 months were compared to the MARs to ensure physician orders are being followed and all orders were printed correctly with no duplicates to include Lipitor orders on 7/27/16 by the Director of Nursing. No concerns were identified. 100% in-service was initiated on 7/27/16 by the Director of Nursing and Staff Facilitator with all Licensed Nursing Staff to include LPN #7 on Mar Tips for Checking Mars to include checking for duplicate orders and the five rights of medication administration be completed on 8/18/16. All newly hired Licensed Nursing Staff with be in-service regarding Mar Tips for Checking Mars to include	

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F 309	Continued From page 9 at 8:00 a.m. and 8:00 p.m. each day. On 7/27/16 at 9:00 a.m. the director of nursing (DON) was shown the duplicate administration of Lipitor 10 mg for Resident #2 and was asked to verify if the twice per day was correct or if the medication was supposed to be administered at each bedtime as listed on the original telephone order. On 7/27/16 at 9:35 a.m. the DON stated the Lipitor 10 mg "printed as a duplicate." The DON stated the medication ordered on 2/25/16 was supposed to be given at each bedtime. The DON stated the Lipitor was administered correctly in March 2016 because the nurse made a handwritten change to the MAR. The DON stated when the printed MAR came from the pharmacy in April 2016, the MAR had duplicate order entries for the Lipitor that resulted in the medication being administered twice per day instead of once per day. The DON stated the nurses reviewed the MARs each month for accuracy but did not catch or question the duplicate Lipitor entry. When asked if pharmacy caught the duplication during their monthly reviews, the DON stated the pharmacist's notes made no mention of the duplicate Lipitor. On 7/27/16 at 11:00 a.m. the facility's consultant pharmacist was interviewed about Resident #2's twice daily Lipitor administration since April 2016. The pharmacist reviewed Resident #2's orders and medication records and stated she did not know how the Lipitor order got on the MAR twice. The pharmacist stated the most recent order on record was dated 2/25/16 for Lipitor 10 mg to be administered at each bedtime. The pharmacist stated, "I didn't notice that it [Lipitor order] was on there [MAR] twice." The pharmacist stated she did not know how the daily order scheduled at	F 309	checking for duplicate orders and the five rights of medication administration during orientation by the Staff Facilitator. The Assistant Director of Nursing will review all newly written physician orders for all residents to include resident #2 and compare to the resident□s Medication Administration records weekly x 8 weeks then monthly x 1 month to ensure medications are being administered per Physician order Utilizing an Physician order QI Tool. The Assistant Director of Nursing will immediately retrain the license nurse, notify the physician, and correct the MAR for any identified areas of concern. The Assistant Director of Nursing, and/or Staff Facilitator will audit all residents to include resident #2 Mars during Monthly MAR checks for a final third check after Staff nurses have completed checks number 1 and 2 before the first of the month to ensure all orders are accurate per physician order to include duplicate entries monthly x 3 months utilizing the QI Tool: MAR Audits. The Assistant Director of Nursing, and/or Staff Facilitator will immediately correct the MAR during the audit for any identified areas of concern. The Director of Nursing will review and initial the Physician Order QI TOOL and QI Tool: MAR Audits weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will compile audit results of the Physician order QI Tool and QI Tools: MAR Audit to the Quality	

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F 309	Continued From page 10 8:00 a.m. was printed on the MAR as the latest order required the medication to be given at each bedtime. The pharmacist stated she did not notice or question the duplicate orders during her monthly reviews. On 7/27/16 at 3:25 p.m. the licensed practical nurse (LPN #7) administering medications to Resident #2 was interviewed about the Lipitor. LPN #7 reviewed the MAR and stated the Lipitor had been given at 8:00 a.m. and 8:00 p.m. each day. LPN #7 stated she sometimes worked the day shift and sometimes worked the evening shift and had given and signed off the Lipitor as listed on the MAR. LPN #7 stated she did not realize there were duplicate orders for the Lipitor. LPN #7 stated she gave the medications as they were listed on the MAR. The Drug Information Handbook for Nursing 13th edition on page 105 describes Lipitor as and antilipemic agent used for the treatment of dyslipidemias or primary prevention of cardiovascular disease. The reference lists the general Lipitor dose range for adults as 10 to 80 mg once daily. (1) These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 7/27/16 at 1:45 p.m. (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.	F 309	Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h)	F 323		8/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 07/28/2016

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 323	Continued From page 11 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility failed to ensure safety devices were in place for one of 20 resident's, Resident #6. Resident #6 did not have automatic braking system or anti-roll back attached to wheelchair as care planned. Findings Include: Resident #6 was admitted to the facility on 1/14/16 with diagnoses including, but not limited to: Diabetes, hypertension, depression, and muscle weakness. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/12/16. Resident #6 was assessed as being severely cognitively impaired with a total cognitive score of 3 out of 15. Resident #6's clinical record was reviewed on 7/26/16 and yielded at care plan with a revision date of 4/19/16 for "Risk for falls [...]" Interventions for risk of falls included; "Anti-roll back on wheelchair" and "Auto brake system on	F 323	Resident # 6 was provided the appropriate proper wheelchair on 7/27/16 to include all care planned safety devices of auto braking system and anti- roll back by 7/27/16. A 100% audit was conducted by the Director of Nursing on 7/27/16 of all current resident□s to include resident #6 to ensure proper safety devices were in place according to the care plan and care guide. No concerns were found during the audit. 100% in-service with all license nurses, CNAs to include CNA # 4, and therapy staff was initiated by the Director of Nursing and Staff facilitator on 7/27/16 on ensuring all residents have proper safety devices in place according to their care guide and care plan and procedure to follow if device is not in place to be completed by 8/18/16. All newly hired license nurses, CNAs, and therapy staff will be in-serviced regarding ensuring all residents have proper safety devices in place according to their care guide and care plan and procedure to follow if device is not in place during orientation by the	

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F 323	Continued From page 12	F 323		

wheelchair." Both interventions were created on 1/25/16 and reviewed and continued on 7/14/16.

Review of the current physician's order set (POS), dated and signed by the physician on 7/1/16, documented "care plan & discharge plan approved as written."

Review of nursing progress note indicated that Resident #6 most recent fall was 7/21/16 and without injury.

On 7/27/16 at 7:40 a.m. Resident #6 was observed in the dining room for breakfast. Resident #6 was in a wheelchair without anti-roll back or auto breaking system to the wheelchair. This observation was pointed out to another surveyor, validating the observation.

On 7/27/16 at 7:45 a.m. this surveyor went to the therapy department and asked an occupational therapist (identified as other staff, OS #7) to accompany this surveyor back to the dining room where Resident #6 was sitting. OS #7 also made the observation and verbalized that was not the correct wheelchair and pointed to another Resident to identify what an auto braking system and anti roll back device would look like.

OS #7 also verbalized that Resident #6 had recently went out with family and that maybe a wheelchair was switched so that the wheel chair could fit into a vehicle.

On 7/27/16 at 7:55 a.m. this surveyor interviewed the certified nursing assistant who got Resident #6 out of bed (identified as CNA #4). CNA #4 verbalized that she used the wheelchair that was in Resident #6's room. This surveyor then

Staff Facilitator. The Assistant Director of Nursing and Staff Facilitator was in-serviced by the Administrator and the Director of Nursing on the QI Tool: Hallway Rounding Sheet to be completed by 8/18/16.

The Assistant Director of Nursing and Staff Facilitator will conduct rounds auditing 10% of residents 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month utilizing the QI Tool: Hallway Rounding Sheet to ensure proper safety devices are in place according to the resident care plan and care guide. Devices will be immediately placed by the Assistant Director of Nursing and Staff Facilitator with retraining to the License nurse and CNA for all identified areas of concern during the audit. The Director of Nursing will review and initial the QI Tool: Hallway Rounding Sheet weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concerns have been addressed.

The Director of Nursing will compile audit results of the QI Tool: Hallway Rounding Sheet and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.

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F 323	Continued From page 13 explained the type of wheelchair Resident #6 was supposed to be using and CNA verbalized that she should have read the care plan. This surveyor and CNA #4 went to Resident #6's room and no other wheelchairs where in the room. CNA #4 then verbalized that she thought Resident #6's wheelchair was being repaired. Within a minute of the conversation OS #7 came up the hall pushing a wheelchair and verbalized to this surveyor that she had found Resident #6's wheelchair down stairs. On 7/27/16 at 8:20 a.m. this surveyor interviewed the maintenance director (OS #6) regarding any work orders for Resident #6's wheelchair. After reviewing all recent work order OS #6 verbalized that if Resident #6's wheelchair need to be fixed then a work order would have been filled out. This surveyor asked OS #6 about extra parts for wheelchairs. OS #6 took this surveyor downstairs and pointed out multiple wheelchairs and parts and verbalized if a wheelchair needs to be fixed, the facility has plenty of parts or other wheelchair to swap out until the wheelchair can be fixed. On 7/27/16 at 1:40 p.m. the above finding was brought to the attention of the administrator and director of nursing (DON). The DON verbalized understanding. No other information regarding the above finding was presented prior to exit conference on 7/28/16.	F 323		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		8/22/16

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F 428	Continued From page 14 CFR(s): 483.60(c) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to identify and report a discrepancy in the medication regimen for one of 20 residents in the survey sample. The pharmacist failed to recognize and report that Resident #2 was administered the medication Lipitor twice per day when the physician ordered the medication once per day. The findings include: Resident #2 was admitted to the facility on 12/1/14 with a re-admission on 1/13/15. Diagnoses for Resident #2 included gastrointestinal bleed, anemia, cardiomyopathy, congestive heart failure, duodenal ulcer, hyperlipidemia, urinary tract infection, pedophilia, peripheral vascular disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease and hypertension. The minimum data set (MDS) dated 5/4/16 assessed Resident #2 with moderately impaired cognitive skills.	F 428	The MD was notified of Resident #2 receiving Lipitor twice per day instead of the ordered once per day x 3 months, by the Director of Nursing on 7/27/16. New orders were received on 7/27/16 to clarify the Lipitor order for 10mg PO q HS and to obtain a stat Lipid Panel. Corrections were made to resident□s #2 MAR by Director of Nursing on 7/27/16. A stat Lipid was obtained on 7/27/16 with results received on7/27/16 and within normal range. The was MD notified of resident #2 Lipid results by the Director of Nursing with no further orders on 7/27/16. A 100% audit of all current resident□s to include resident #2 physician orders for the last 3 months were compared to the MARs to ensure physician orders are being followed and all orders were printed correctly with no duplicates to include Lipitor orders on 7/27/16 by the Director of Nursing. No concerns were identified.	

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F 428	Continued From page 15 Resident #2's clinical record documented a physician's telephone order dated 2/25/16 for Lipitor 10 mg (milligrams) to be administered at each bedtime for the treatment of hyperlipidemia. The resident's medication administration records (MARs) for April 2016, May 2016, June 2016 and July 2016 (through 7/26/16) documented 10 mg of Lipitor was administered twice per day instead of once per day as ordered. The MARs had duplicate order entries for the Lipitor 10 mg with nurses documenting the Lipitor was administered at 8:00 a.m. and 8:00 p.m. each day. The clinical record documented monthly pharmacy reviews dated 4/22/16, 5/24/16 and 6/24/16. The pharmacist's notes made no mention of duplicate Lipitor orders or duplicate doses of Lipitor administered to Resident #2. On 7/27/16 at 9:00 a.m. the director of nursing (DON) was shown the duplicate administration of Lipitor 10 mg for Resident #2 and was asked to verify if the twice per day was correct or if the medication was supposed to be administered at each bedtime as listed on the original telephone order. On 7/27/16 at 9:35 a.m. the DON stated the Lipitor 10 mg "printed as a duplicate." The DON stated the medication ordered on 2/25/16 was supposed to be given at each bedtime. The DON stated the Lipitor was administered correctly in March 2016 because the nurse made a handwritten change to the MAR. The DON stated when the printed MAR came from the pharmacy in April 2016, the MAR listed duplicate order entries for the Lipitor that resulted in the medication being administered twice per day instead of once per day. The DON stated the nurses reviewed the MARs each month but did not catch the duplicate Lipitor entry. When asked	F 428	100% in-service was initiated on 7/27/16 by the Director of Nursing and Staff Facilitator with all Licensed Nursing Staff to include LPN #7 on Mar Tips for Checking Mars to include checking for duplicate orders and the five rights of medication administration be completed on 8/18/16. All newly hired Licensed Nursing Staff with be in-service regarding Mar Tips for Checking Mars to include /checking for duplicate orders and the five rights of medication administration during orientation by the Staff Facilitator. In-service with internal pharmacy staff re: importance of identifying and acting upon duplicate orders conduct by the Pharmacy Manager to be completed by 8/22/16. In-service with Consultant Pharmacist to emphasize the importance of identifying and acting upon duplicate entries on the MAR conducted by the Pharmacy Manager on 8/17/16. Manual review of all orders printed from the pharmacy database by Pharmacy□s Regional Clinical Manager to verify that duplicate entries are not present to be completed by 8/19/16. Any concerns identified will be addressed immediately. The Assistant Director of Nursing will review all newly written physician orders for all residents to include resident #2 and compare to the resident□s Medication Administration records weekly x 8 weeks then monthly x 1 month to ensure medications are being administered per Physician order Utilizing an Physician order QI Tool. The Assistant Director of Nursing will immediately retrain the	

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F 428	Continued From page 16 if pharmacy caught the duplication during the monthly reviews, the DON stated the pharmacist's notes made no mention of the duplicate Lipitor. On 7/27/16 at 11:00 a.m. the facility's consultant pharmacist was interviewed about Resident #2's duplicate Lipitor administration since April 2016. The pharmacist reviewed Resident #2's orders and medication records and stated she did not know how the Lipitor order got on the MAR twice. The pharmacist stated the most recent order on record was dated 2/25/16 for Lipitor 10 mg to be administered at each bedtime. The pharmacist stated, "I didn't notice that it [Lipitor order] was on there [MAR] twice." The pharmacist stated she did not know how the daily order scheduled at 8:00 a.m. was printed on the MAR as the latest order required the medication to be given at each bedtime. The pharmacist stated she did not notice or question the duplicate orders during her monthly reviews. These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 7/27/16 at 1:45 p.m.	F 428	license nurse, notify the physician, and correct the MAR for any identified areas of concern. The Assistant Director of Nursing, and/or Staff Facilitator will audit all residents to include resident #2 Mars during Monthly MAR checks for a final third check after Staff nurses have completed checks number 1 and 2 before the first of the month to ensure all orders are accurate per physician order to include duplicate entries monthly x 3 months utilizing the QI Tool: MAR Audits. The Assistant Director of Nursing, and/or Staff Facilitator will immediately correct the MAR during the audit for any identified areas of concern. The Director of Nursing will review and initial the Physician Order QI TOOL and QI Tool: MAR Audits weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will compile audit results of the Physician order QI Tool and QI Tools: MAR Audit to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	
F 463 SS=D	RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH CFR(s): 483.70(f) The nurses' station must be equipped to receive	F 463		8/22/16

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F 463	Continued From page 17 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a properly functioning communication system to receive calls from one common area bathroom. The facility staff failed to ensure a functioning call bell system for one common area bathroom (left) located near the Unit 1 nursing station. The light did not illuminate at the panel. Findings include: During general observations of the facility environment on 07/27/16 at approximately 8:15 a.m., a common area bathroom on nursing unit 1 was tested. The (left) bathroom was tested, the bathroom door was not locked, the door was opened and near the toilet was a red call bell push button, the button was pushed. This surveyor exited the (left) bathroom and stood out in the hall. There was no sound to indicate the bathroom call bell system had been activated. A light was located above the (left) bathroom, close to the ceiling. The light had no cover, just a single clear light bulb, which was on (not blinking). This surveyor stood in the hall way for approximately 5-7 minutes as staff members and residents went up and down the hall. The light was not recognized by any staff member and no	F 463	Work order was completed on 7/27/16 by the Director of Nursing for the call bell for Unit 1 Common area bathroom on left side to include call bell control panel bulb. This was fixed and corrected by the Maintenance Director on 7/27/16. 100% audit was completed by the Maintenance Director and the Maintenance Assistant of all call bells to include common area bathrooms and shower rooms on both units to ensure proper functioning of call bell system to include call bell control panel on 8/15/16. The Maintenance Director and the Maintenance Assistant immediately repaired any identified areas of concern during the audit. 100% of all License nurses, CNAs, Dietary, housekeeping, therapy staff, and department managers was in-service by the Staff Facilitator and the Director of Nursing on reporting and filling out work orders for defective equipment to include call bells not properly working to be completed on 8/18/16. All newly hired License nurses, CNAs, Dietary, housekeeping, therapy staff, and department managers will be in-serviced regarding reporting and filling out work orders for defective equipment to include call bells not properly working during orientation by the Staff Facilitator.	

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F 463	Continued From page 18 attempt was made by staff to check the bathroom. At approximately 8:25 a.m., LPN (Licensed Practical Nurse) # 8 was interviewed at the Unit 1 nursing station. The LPN was asked how someone would know if either of these bathroom call systems had been activated. The LPN looked down the hall toward the bathroom, and voiced you would look for a light, but neither of the lights outside of the bathroom were visible from the nursing station. The LPN then looked at the call bell control panel at the nursing station and voiced, there should be a loud ringing so you can hear it and the board lights up. The LPN was made aware that the call bell system in the (left) bathroom had been activated and there was no light. The LPN looked at the control board and agreed. The LPN was then taken to the (left) bathroom, the LPN looked up and saw the light on, close to the ceiling and agreed the light could not be seen from the nursing station and additionally agreed that there was no alarm and that the control panel for the (left) bathroom was not working. At approximately 8:30 a.m., the MS (maintenance supervisor) was asked how often call bell lights/systems are checked. The MS voiced that they are checked weekly and that there is a log for that. The MS was asked if that was for resident rooms only or for the common area bathrooms, as well. The MS voiced that all call bells are checked weekly and they are random checks, it was not specifically documented which rooms or which bathrooms were checked. The MS was informed of the above information regarding the call bell system concern with the Unit 1 common area bathroom on the left.	F 463	The Administrator in-serviced the Maintenance Director and Maintenance Assistant on proper function of call bell system on 8/15/16. The Maintenance Director and/or the Maintenance Assistant will audit 10% of all call bells to include common areas on both units and call bell control system weekly x 8 weeks, then monthly x 1 month to ensure proper functioning using QI Tool: call bell monitoring. The Maintenance Director and/or the Maintenance Assistant will immediately repair any identified areas of concern during the audit. The Administrator will review and initial the QI Tool: call bell monitoring weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will compile audit results of the QI Tool: Call bell monitoring and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	

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F 463	Continued From page 19 At approximately 8:45 a.m., the MS voiced that the bulb was out on the call bell control panel and that is why it did not light up for the left bathroom when activated. The MS was asked if had a work order for the bathroom. The MS voiced, yes I have work orders. The MS was asked if he had work orders for the light in the control panel. The MS voiced, no. The administrator, DON (director of nursing), nurse consultant and regional vice president were made aware of the above concerns during a meeting with the survey team on 07/27/16 at approximately 1:45 p.m. No further information or documentation was presented prior to the exit conference on 07/28/16 at 10:15 a.m.	F 463		
F 518 SS=D	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure one of 8 staff members interviewed was knowledgeable of emergency protocols for a power outage. Certified nurses' aide (CNA) #2 was not aware the facility had a generator, had generator	F 518	CNA # 2 was in-serviced by the Staff Facilitator on 7/28/16 on Electrical Outage. 100% of all license nurses, CNAs to include CNA #2, dietary staff, therapy	8/22/16

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F 518	Continued From page 20 powered red outlets or of emergency lighting available in case of a power outage. The findings include: On 7/27/16 at 8:30 a.m. CNA #2 was interviewed about emergency procedures in case of a power outage. CNA #2 stated when the electricity was off they just waited for the lights to come back on. When asked if they had any power supplied when the electricity was off, CNA stated she was not aware of alternate power. When asked if they had a generator that came on when the power was out, CNA #2 stated, "I don't think we have a generator." When asked if they had any special outlets to use when the power of out, CNA #2 stated, "Not that I'm aware of." When asked what was done about lighting in the facility when the power was off, CNA #2 stated if lights were off for an extended time the maintenance employees brought around flashlights. On 7/28/16 at 8:40 a.m. the registered nurse staff development coordinator (RN #2) was interviewed about CNA #2's lack of knowledge concerning power outage protocols. RN #2 stated CNA #2 had been trained on emergency procedures in 2015 but had not yet been re-educated in 2016. RN #2 stated CNA #2 said she was "nervous" when questioned about the emergency protocols. RN #2 stated CNA #2 had worked in the facility "for a long time" and should have been familiar with the protocols for a power outage. On 7/28/16 at 9:10 a.m. RN #2 presented a copy of in-service education records documenting CNA #2 was educated in June 2015 regarding the facility's emergency procedures. The facility's policy titled Electrical Outage	F 518	staff, housekeeping staff, and department managers were in-serviced by the Staff Facilitator and Director of Nursing on emergency procedures to include Electrical Outage to be completed on 8/18/16. Any newly hired staff will be in-serviced regarding emergency procedures to include Electrical Outage during orientation. The staff Facilitator will interview 10% of staff members to include all departments weekly x8 weeks and then monthly x 1 month on emergency procedures to include Electric outage utilizing the Emergency Procedure Questionnaire QI Tool. Any concerns identified on the questionnaire will result in that staff member receiving individual retraining immediately by the Staff Facilitator. The Administrator will review and initial the Electrical Outage Questionnaire weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will compile audit results of the Emergency Procedure Questionnaire and present to the Quality Improvement Committee Meeting monthly x 3 months. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 518	Continued From page 21 (revised 6/08) stated, "Electrical power is supplied by a primary source on a continuous basis. In the event that this source is unavailable, alternate power is supplied by an automatic system or back-up generator...The alternate power supply is automatic with an average ignition delay of three to five seconds from power outage to generator ignition. Certain lights throughout the facility will remain on with generator power. Emergency outlets are available and located throughout the facility..." These findings were reviewed with the administrator, director of nursing and nurse consultant during a meeting on 7/28/16 at 9:30 a.m.	F 518		